MCHJ-Q 31 October 2002

MEMORANDUM FOR Quality Management Directorate, ATTN: Dr. Charles Deal, US Army Medical Command, San Antonio, TX

SUBJECT: 2002 Triennial Survey After Action Report

1. Madigan Army Medical Center (MAMC) underwent a JCAHO triennial survey the week of 21-25 October 2002. The previous survey was conducted in October 1999. Preparations for current survey began shortly after the last survey with emphasis and focus being placed on ongoing compliance. Escalation of the process increased approximately one year out.

2. Application for the survey arrived in March 2002. We completed the electronic application and with the exception of a few small glitches with the software, we thought this was much easier than completing the paper application. The application requested that survey dates be scheduled after 30 September 2002, the end of our fiscal year.

3. A Continuous Compliance Committee was established shortly after the 1999 survey to assess new standards, changes in the standards and to assess Madigan's compliance with those standards. In addition, a Continuous Compliance Course was developed. The course was taught quarterly in the two years after the survey and was taught about every other month in 2002. The course is geared for Head Nurses, OICs and NCOIC's and was designed to help them learn skills to maintain a fully compliant ward or service on an ongoing basis. About one third of Madigan's military turned over the summer of 2002 and it was a huge challenge to get these people onboard, oriented to Madigan and giving Madigan-specific answers to questions. This course assisted with the assimilation.

4. Survey Preparation.

a. In April 2001 (about 18 months out from survey) MAMC conducted a mock survey using internal assets as the mock surveyors.

b. In January 2002, MAMC contracted with Joint Commission surveyors who work part time as consultants to conduct a mock survey of the hospital.

c. In September 2002, two Joint Commission Resources surveyors assisted with survey preparation - primarily with preparation for interviews.

d. In the months leading up to the survey, a sample leadership question was asked at the weekly Thursday morning report to help prepare Division and Department Chiefs for survey. This proved quite successful in helping prepare staff to answer JCAHO questions using the Socratic method.

e. Three weeks in advance of the survey, the survey escort officers, LTC Curtis Hobbs, physician escort, COL Nancy Hodge, nurse escort, and LTC Greg McKee, administrative escort, in conjunction with the respective Deputy Commander conducted a full week long survey -- mirroring the exact survey schedule to insure there were no scheduling conflicts as well as to provide practice for staff.

f. Two weeks in advance of the survey, the scribes for each team - CPT Dan Bonnichson and MAJ Rosemary Mackey, admin residents and CPT Carolyn Gales, Consolidated Education, followed up with each area to confirm resolution of previously identified issues.

g. QSD was actively preparing the documents for review during this timeframe. Joint Commission published a new format for document review organization about a month in advance of our survey. We had organized our documents according to the JCAHO chapter for our 1999 survey and this was very successful. The new format requests documents be assembled in this fashion, however, the document is not overly clear - and our surveyors had not seen the new format nor did they know JCAHO was requesting hospitals compile documents in that format. We provided the JCAHO format document to them for review.

h. Several special teams were also organized to assist with preparation. One team, led by the Executive Officer, LTC Lance Maley, evaluated 6-part folders. Another team, led by 1LT Christine Iverson, QSD and MAJ Rebecca Preza, CMS, tackled standardization of crash carts. COL George Dydek, Chief, Pharmacy, led a group addressing pharmacy issues (overrides, security, etc.)

5. Many people requested to observe the survey process. The Command chose to limit this to three observers (1 with each team). Two from our region attended as observers - the DCCS from Bassett ACH and the QI Coordinator from Weed ACH. Additionally, Eisenhower AMC sent an observer. There is a balance between using the survey process as a learning tool for those who are not familiar with the issues of confidentiality and crowds and accompanying entourage.

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6. JCAHO "headquarters" was the Conference Room in the QSD hallway. A table accommodated the various documents. A mobile file was also placed in the

room with copies of minutes and any other materials we thought important for the surveyors to see. The room was equipped with three lines so the surveyors could hook up their laptops. Each surveyor was issued a key so that the room could be secured at all times and they could therefore store personal belongings in the room during their absence.

7. Finally, with all these preparations behind us, the day arrived for the real survey to begin. Our ambulatory survey was scheduled for Monday, 21 Oct 02 and the physician and nurse surveyors arrived to conduct that survey. Also, the behavioral surveyor called the Friday before the survey and asked if she could come on Monday instead of Tuesday as was planned due to a scheduling problem with the Joint Commission. Our ASAP personnel were gracious and able to accommodate that request, so the behavior health surveyor, Carol Cook also arrived on Monday. She completed her review in one day and furnished her findings to the other surveyors for inclusion in their final report.

8. "JCAHO Central" was set up within the QSD office during the survey. This office was manned with individuals available to take phone calls and messages. An escort, a scribe and a runner were identified for each survey team. The scribes would take notes and have the runners bring them back to JCAHO Central. The notes were immediately transcribed and in turn put out on Outlook and CHCS for the staff's information. The notes included questions asked by the surveyors in the various locations as well as any areas or issues that would seem to be a "theme" with the surveyor. Although these notes were long and sent often throughout the day, staff offered positive feedback and appreciated being kept current on the proceedings of the survey.

9. Following the exit conference, an open forum was held by the Commander in Letterman Auditorium to deliver the survey results to the staff. The staff had worked very, very hard in preparation for the survey and were eager for the feedback. Sincere thanks to the staff for their hard work was offered by both the hospital and the regional Commanders.

10. At Enclosure please find a copy of our findings from the survey as well as the questions asked by each of the surveyors at each of the locations surveyed. Once the final report is received, we intend to reclamma several of the findings.

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Encl Lisa Danforth-Lewis
Chief, Quality Services Division

21-25 Oct 02 STANDARD/FINDING	ISSUE (Madigan AMC)
LD.5 – A **Patient Safety** program has been implemented.	There was no evidence of an annual report to the governing body on medical/healthcare errors and actions taken to improve patient safety, both in responses to actual occurrences and proactively within the last 12 months.
LD.5.2 - Leaders ensure program for identifying **risks** to **patient safety** and reducing errors is implemented.	Although a Failure Mode and Effects Analysis (FMEA) had been demonstrated, there was no evidence of a root cause analysis (RCA) being performed on high criticality points.
IM.7.3.2 – Patient specific data relative to care process is captured (IM.7). **Operative reports** are dictated or written immediately after surgery.	AR 40-66 7c allows dictated operative reports be completed within 24 hours following surgery. Only 69% were dictated on the day of surgery.
IM.7.10 - Patient specific data relative to care process is captured (IM.7). **Medical records** are reviewed for completeness and timeliness of information/action taken to improve quality of documentation that impacts patient care.	1) Data regarding donation and receipt of transplants and/or implants was only collected in 3 of the last 4 quarters. 2) H&Ps done by residents should be concurrently reviewed by staff for pertinence. 3) Documentation quality of ER records is poor...5 of 6 records reviewed were deficient in some way 4) Data collection regarding patient learning is inconsistent in the ambulatory clinics 5) Process for nutritional assessment in OB/GYN clinic was less objective than screening processes in other clinics. 6) Co-documentation by a privileged provider was considered insufficient on one chart where a medical student had documented an exam in the ED.
PE.1.15 – Quality control checks are conducted on each procedure.	OB/GYN was using pH paper with no expiration date on the container as well as no QC being conducted on the paper.
PE.3 – Patient assessment Information is integrated to identify and assign **priority of care.**	Open medical record review did not consistently provide evidence of prioritization of patient care needs.
TX.3.3 – Policies and procedures support safe **medication prescription** or ordering.	1) 23 of 89 documentations of controlled substance administrations in Radiology lacked required signatures. 2) Mixing of epinephrine with local anesthetic in Plastic Surgery clinic was questioned since such solutions were already available.

TX.3.5.5 – **Emergency medications** are consistently available, controlled and secure in the pharmacy and patient care areas.	There was no process to verify the integrity of locks on "tackle boxes" holding emergency medications on the OB unit.
TX.7.1.7 – Written or verbal orders for initial/continuing use of **restraints** are time limited.	Review of closed medical records on restraint patients did not consistently reflect the amount of time restraint order was valid.
TX.7.1.8 – Patients in **restraints** are regularly evaluated.	Psych restraint patients were not being re-evaluated IAW organizational policy (every 4 hours by LIP). Also pointed out our policy is more restrictive than required by JCAHO.
PI.3.1 – The organization collects data to monitor its **performance**.	Measurement to assess patient's perception of safety has not been implemented.
PI.3.1.1 – The organization collects data to **monitor the performance** of processes that involve risks or may result in sentinel events.	Patient satisfaction regarding effective pain management has not been assessed.
PI.4.3 – Undesirable patterns or trends in performance and sentinel events are **intensively analyzed**.	1) A large amount of near misses was attributed to high number of pharmacy dispensing errors. There was evidence that patients were sent home with wrong medication as well as no evidence of improvements in the process. 2) Staff turnover rates were identified for high blood culture contamination rates. However, there was no indication of proactive training of new staff to draw cultures in a sterile manner.
LD.1.6 – Leaders provide for **uniform performance** of patient processes.	Record of child receiving Ketamine sedation in the ER did not contain proper assessment IAW moderate sedation policy. Forms to record assessment are not consistent with practice throughout facility.
EC.1.4 – The organization has an **emergency management plan**.	There was no completed Hazard Vulnerability Assessment (HVA) for Okubo or old Madigan. Response procedures for highly probable risks have not been developed and subsequently drilled.
EC.2.1 – The hospital implements its **safety plan**.	1) Multiple issues: cigarette butts on roof, improper signage in stairwells, 5N: potential suicide issues (shower heads, open grab bars, metal shower curtain hooks, etc.), accessible fire extinguishers, unsecured acetylene cylinder. 2) Metal items (crash cart, oxygen cylinders) present in MRI.
EC.4.2 – The hospital	Review of minutes from Safety Committee (consisting of 22 members) revealed they met 11 times

analyzes identified **environment issues** and develops recommendations for resolving them.	during the period Oct 01 through Sep 02 with five members absent for five or more meetings thus potentially negatively impacting committee dialogue, deliberations and effectiveness. Further, during 2001, there was no DENTAC representation at any meeting and the Health Physician member was absent 10 of the 11 meetings. On the positive side, it was noted that the AFGE member's attendance had improved from being absent 9 of 11 meetings in 2001 to being absent only 1 of 9 meetings in 2002.
HR.4 – An **orientation process** provides initial job training and information and assesses the staff's ability to fulfill specified responsibilities.	New employees are oriented departmentally by a preceptor. One human resources file reviewed did not consistently provide evidence of documentation accurately describing the timeliness of orientation of employees. One employee was hired the end of June but the departmental orientation was not documented until mid-September.
HR.4.3 – Aggregate data is collected on competence patterns and trends to identify and respond to **staff leaning needs**.	Annual competency report to the EBOD did not address levels of competency for non-medical staff privileged providers or for various other spectrums of patient care givers. Further, volunteer nurses providing care were not included in the report.
IM.7.8 – Every **medical record** entry is dated, author identified and authenticated, when necessary.	In all open records review, manual signatures on written documentation did not always contain a method of identifying the author.
IC.4 – Action is taken to prevent or reduce the risk of **nosocomial infections**.	1) Documentation of testing CIDEX OPA was not consistent with hospital policy. 2) Endoscopes in two areas were stored in open air areas after washing which exposed them to contamination. Scopes should be protected against contamination and possible damage. 3) Old reusable needles in glass tubes with cotton in each were found in the plastic surgery clinic.
MS.5.12.1 – Appraisal for reappointment of medical staff or renewal/revision of clinical privileges is based on ongoing monitoring of information concerning the individual's **professional performance**.	Practitioner specific information had not been aggregated so it could be compared to peer performance and analyzed to detect variant practices.